GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation &
Licensing Administration

SENT VIA FACSIMILE & MAILED

December 20, 2007

Kimberly Scott-Hopkins
Executive Director
My Own Place
817 Varnum Street, NE
Washington, DC 20017

RE: 4141 Anacostia Ave., NE

Dear Ms. Scott-Hopkins:

You will find enclosed Statement of Deficiencies reports for D.C. licensure and federal certification. The reports enumerate deficiencies found as a result of a **monitoring survey** conducted on December 12, 2007. You are required to respond to each deficiency. Although a reasonable period of time may be allowed for actual correction of these deficiencies, it is imperative that your plan, with specific date for anticipated completion, be signed, dated and returned to this office prior to **January 2, 2008**. Since these reports are subject to public disclosure, it is necessary that the responses be indicated on the forms (and not on an attachment, except if submitting a copy of a policy change). NOTE: "Corrected" is not an accepted reply. An acceptable plan must also include the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented.

PLEASE NOTE: Failure to submit acceptable plans, within the specified time frame, MAY RESULT in the loss of Medicaid reimbursement.

If you have any questions or concerns regarding the above, please contact Ms. Sheila Pannell, Supervisor of the Intermediate Care Facility Division on (202) 442-5888.

Sincerely,

Patricia W. VanBuren

Patricia W. VanBuren
Program Manager

Enclosure

cc: Department on Disability Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G127	A. BUILDING _____ B. WING _____	C 12/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A monitoring visit was conducted subsequent to the annual recertification survey which was completed on 10/12/2007 was conducted on 12/12/2007. This monitoring visit was initiated after the facility submitted a Plan of Correction which alleged full compliance would be achieved on 10/30/2007. Observation, staff interview, record review and a review of the facility ' s presented plans of correction revealed the provider failed to enact and enforce the necessary measures required to abate the deficiencies cited below.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on staff interview and record review the facilities governing body continued to failed to enact the necessary measures to provide general operating direction over the facility as described below. The findings include: The facility alleged that by 10/30/2007 the following actions would be taken to address the deficiencies cited during the 10/12/2007 re-certification survey: 1. The POC alleged that the Director of Health Services would provide all medication nurses and TME ' s additional training on how to properly document the administration of all dispensed medications and treatments. 2. The POC also alleged that the " delegating Registered Nurse " would review the MAR at least once weekly to monitor the documentations.	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 3. The POC also stated that the director of Health Services would conduct a quality assurances of the client medical administration records and provide the follow-up as necessary to ensure the accurate documentation of administered medications and nursing compliance with established protocols. During the monitoring visit conducted on 12/12/2007, the facility failed to provide any written documentation that any of the nursing and TME trainings were completed; failed to provide any evidence that the " delegated Registered Nurse conducted the necessary reviews of the MAR; and failed to provide any evidence that the director of Health Services had conducted any QA reviews of the clients medical records. The facility failed to ensure the provisions of their Plan of Correction and has failed to resolve the deficient practices as cited in the 10/12/207 re-certification survey.	W 104		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to establish and maintain an effective system that ensures the complete and accurate accounting of client ' s funds. The findings include: 1. The facility alleged that on 10/22/2007 the Resident Manager submitted the original receipts for the monies that were in question during the 10/12/2007 re-certification survey. The facility also alleges that the resident manager would	W 140		

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W 140	Continued From page 2 reconcile all withdrawals from a client ' s bank accounts within 30 days. Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) at 3:48pm revealed, this had always been the procedure in place and that the response on the plan of correction was not a procedural change. Despite that being the system that was in place, a full and accurate account of client ' s funds could not be account for during the annual re-certification survey on 10/12/2007 and again during the monitoring visit conducted on 12/12/2007. There was no evidence presented or on file at the time of the monitoring visit to substantiate that any measures had been enacted to ensure that client ' s personal finances were being managed and accounted for as required by this section. 2. The facility alleged that on 10/22/2007 the Qualified Mental Retardation Professional (QMRP) would audit and reconcile all client ' s funds and verify all purchases prior to the submission of receipts to the Administrator ' s Office. In addition, a tracking sheet for all withdrawals had been implemented and would be forwarded to the program director for follow-up prior to the reconciliation date. Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) on 12/12/2007 at 3:53pm revealed the tracking system that was supposedly implemented was already the system that was in place and was standard procedure. The Qualified Mental Retardation Professional (QMRP) provided the survey team with a copy of the document she believed to be the tracking sheet mentioned in the plan of correction, but was not able to show that evidence of her audits/reconciliations. In addition, there was also no evidence that the program director was being provided the monthly audits. There was no	W 140		

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W 140	Continued From page 3 evidence presented or on file at the time of the monitoring visit to substantiate that any measures had been enacted to ensure that client ' s personal finances were being managed and accounted for as required by this section and as presented in the plan of correction.	W 140		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that an effective system of monitoring all reportable incidents was implemented as presented in the plan of correction. The finding includes: The facility alleged that by 11/1/2007 and in an " ongoing " fashion, the Incident Management Coordinator would review all incidents and follow-up recommendations via the implementation of a tracking system. Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) on 12/12/2007 at 3:59pm revealed she was not aware of the " tracking " system that was mentioned in the plan of correction and that this was all managed at the Administration ' s Office. There was no evidence presented or on file at the time of survey to substantiate that the facility enacted a " tracking system " that would ensure the timely monitoring/review of all reportable incidents.	W 153		

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W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure staff received the proper and necessary training to ensure the proper use of client ' s adaptive equipment; failed to ensure TME and nursing training on proper documentation of self medication programs; . The finding includes: 1. The facility alleged that by 11/1/2007 and in an " ongoing " fashion, the facility ' s staff would have received the proper and necessary training to ensure that Client #3 was able to effectively utilize his protective gloves when he ' s independently ambulating in his wheelchair. Interview and record review with the facility ' s Qualified Mental Retardation Professional (QMRP) on 12/12/2007 at 4:17pm revealed there was no evidence on site to substantiate that staff had received training on the maintenance and implementation of Client #3 ' s gloves . The facility failed to implement the proactive measures as identified in their plan of correction and as cited during the 10/12/2007 re-certification survey. 2. The facility alleged that by 10/30/2007 and in an " ongoing " fashion, the facility would ensure the following: a. All TME ' s and Nursing staff would have received the proper and necessary training to ensure the accurate documentation of client ' s self-medication programs. b. The Qualified Mental Retardation Professional	W 189		

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W 189	Continued From page 5 (QMRP) would review and monitor the data collection sheets on a weekly basis and document as such in her monthly " Q Notes " . c. The " Delegating Registered Nurse " would monitor the completion of data during the weekly review of the MAR documentation. d. The Director of Health Services would audit the records to monitor for consistent documentation of the self-medication programs and follow-up as necessary for any noted discrepancies. During the monitoring visit conducted on 12/12/2007, the facility ' s Qualified Mental Retardation Professional (QMRP) was interviewed at 4:35pm and it was revealed via record review that the facility failed to present any evidence that any of the nursing and TME trainings were completed; failed to provide any evidence that the " QMRP " documented her weekly monitoring in her " Q Notes " ; failed to provide any evidence that the " Delegating Registered Nurse " monitored the completed data on a weekly basis; and failed to substantiate that the Director of Health Services had conducted any monitoring of the self-medication programs. The facility failed to ensure the provisions of their Plan of Correction.	W 189		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.	W 264		

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W 264	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that the Human Rights Committee had reviewed and approved the use of bed rails for any clients residing in the facility. The finding includes: The facility alleged that by 11/1/2007 and in an " ongoing " fashion, the facility ' s staff would have ensured the following: 1. The primary care physician would have reviewed and approved the use of bed rails for any client utilizing them in the facility. 2. A procedure for ensuring client safety while in bed with bedrails was developed and training provided by the Physical Therapist by 11/31/2007. 3. The Delegating Nurse provided training to staff on 10/17/2007 regarding the procedures for ensuring client safety while in bed with bedrails. 4. The Human Rights Committee has reviewed and approved the physician ' s recommendation for the continued use of the bed rails. 5. The Qualified Mental Retardation Professional (QMRP) received additional training on what situations require HRC review. 6. The Qualified Mental Retardation Professional (QMRP) would review all potential risks to the rights of clients with the HRC to address recommendations, approval and monitoring. 7. Evidence of HRC review will be maintained in the client ' s records. During the monitoring visit conducted on 12/12/2007, the facility ' s Qualified Mental Retardation Professional (QMRP) was interviewed at 4:40pm and it was revealed via record review that the facility failed to present any evidence that the primary care physician had reviewed and approved the use of bedrails; failed	W 264		

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W 264	Continued From page 7 to present any evidence that a " procedure " for ensuring client safety had been developed and training provided; failed to provide evidence that the " delegating nurse " had provided any additional training on client safety while utilizing beds with bedrails; failed to present any evidence that the HRC had met or approved the use of bedrails and that approval was filed accordingly; failed to present that the Qualified Mental Retardation Professional (QMRP) received additional training with regards to HRC review; and failed to show evidence that the QMRP and the HRC had met on any measures as presented on the plan of correction. The facility failed to ensure the provisions of their Plan of Correction and has failed to resolve the deficient practices as cited in W264 for the 10/12/207 re-certification survey.	W 264		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the provision of general medical care. The finding includes: The facility alleged that by 11/21/2007 and in an " ongoing " fashion, the facility ' s nursing staff would have ensured the following: 1. Medical appointment completion would be monitored by the delegating Registered Nurse at the monthly medical record review with the Qualified Mental Retardation Professional (QMRP) and the Residence Manager. 2. The creation of a follow-up response form to	W 322		

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W 322	Continued From page 8 communicate the action of items identified at the monthly health services review. 3. A copy of this form would be forwarded to the Director of Health Services for review. 4. Evidence of appointment completion would be forwarded to the delegating nurse. 5. Appointment cancellations, delays or refusals would be immediately reported to the delegating nurse for further action. During the monitoring visit conducted on 12/12/2007, the facility ' s Qualified Mental Retardation Professional (QMRP) was interviewed at 4:43pm and aided in the record review to ascertain the effectiveness of plan of correction. According to the plan of correction, Client #2 was scheduled to have his dental consult completed by 11/30/2007. Record review revealed Client #2 had not received any dental services since 3/21/2005 as cited in W352 on the 10/12/2007 re-certification. In addition, there was no evidence the system that was to be in place ensured the " delegating nurse " caught this discrepancy or took part in the monthly health services review that would have caught this oversight. There was also no evidence that the Director of Health services was notified of the oversight or took part in any proactive measures to ensure the correction of this oversight. The facility failed to ensure the provisions of their Plan of Correction.	W 322		
W 352	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by:	W 352		

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W 352	Continued From page 9 Based on staff interview and record review, the facility failed to ensure that clients received timely dental services as required by this section. The finding includes: During the monitoring visit conducted on 12/12/2007, the facility ' s Qualified Mental Retardation Professional (QMRP) was interviewed at 4:43pm and aided in the record review to ascertain the effectiveness of plan of correction. According to the plan of correction, Client #2 was scheduled to have his dental consult completed by 11/30/2007. Record review revealed Client #2 had not received any dental services since 3/21/2005 as cited in W352 on the 10/12/2007 re-certification. There is no evidence that Steven Fox (Client #2) has been seen by a dentist since the date of survey.	W 352		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that a client was provided the use of protective gloves as identified in the comprehensive assessment. The finding includes: The facility alleged that by 10/29/2007 and in an " ongoing " fashion, the facility ' s Primary Care Physician would have reviewed and approved . Interview and inspection for the glove with the	W 436		

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W 436	Continued From page 10 facility ' s Qualified Mental Retardation Professional (QMRP) on 12/12/2007 at 4:19 pm revealed there was no glove available on site for the survey team to validate that it was made available to the client for use. [Reference W189]	W 436		